

## Overview of Behavioral Health I/DD Tailored Plan RFA Pre-Release Policy Paper Webinar

**Suzanne Thompson:** We would like to welcome all of you to our webcast this afternoon. As part of are DHHS engagement for all of our stakeholders. The focus of today's webinar is going to be an overview of the Behavioral Health I/DD Tailored Plan RFA Pre-Release Policy Paper. The policy paper was published on January 30. It is open for public comment until February the 14th. We have about an hour today to give you the overview as well as answer questions for you. And now I'd like to turn it over to Dave Richard the Deputy Secretary for Medicaid.

**Dave Richard:** Thank you Suzanne. Good afternoon everybody. We're glad you joined us and we're going to have several of us present and walk through those preventatives as we turn it over to each other. So if you look on slide 3, that is really our agenda and obviously we're going to talk about this paper content and we'll start with administration, quality and select program features, provider participation, financial management and monitor and then really hit the next steps as we walk through it. We do encourage you to read the paper but this will be the kind of overview I think will help you as you are thinking about the paper itself.

So let's get started on the background for this effort and most of you know these things but we want to make sure we level set as we go forward and that the reminder is that under our managed care transition, that there are two types of plans that are in place—will be in place—as we go forward. One is the standard plans which are plans that will serve the majority of Medicaid beneficiaries, including those with mild to moderate behavioral health conditions, including mental health and substance use disorder. But, we have as part of our transition plan, although an important component of this is the Behavioral Health I/DD tailored plans. Those plans will serve populations with more serious behavioral health conditions, intellectual and development disabilities and traumatic brain injury. These services will include state-funded behavioral health I/DD, TBI services. 1915(c) innovations and TBI services, and additional high-intensity Medicaid behavioral health services. And a reminder that these plans will offer all behavioral health and medical services for the beneficiaries. A really important point is - at the bottom of the slide which tells us that for now, Medicaid Managed Care has been suspended due to the lack of a new state budget. But the work that we've been doing for tailored plans will continue. Until the new plans go live, individuals who currently access behavioral health I/DD, TBI services through LME/MCOs will continue to do so through those plans as they do today. So nothing changes for anybody until we go live with the launch of managed care.

The next slide, this gives you a timeline of how we plan do to this is that he reminder that for tailored plans only LME/MCOs are able to bid on those. So we will release a request for an application to those seven LME/MCOs. We plan to release it in the spring of 2020. In the summer, the offerors, the LME/MCOs themselves will submit responses. The late fall we'll unveil I/DD plans for the selected LME/MCOs. And in the summer of 2021, is when are intention to launch. Really important to note is that all of this is contingent upon having a budget, a new budget cast in the short legislative session which begins in April. But right now our intention is to follow-through with that launch period in the summer.

Then on slide seven, just a little bit of the tailored plan procurement process. The department will establish criteria for comprehensive and thorough application process for the behavioral health I/DD tailored plan contracts. Really important to note that this going to be a robust effort, one in which requires the LME/MCOs to respond to an application that will identify all of the things that need to be present for a tailored plan to be successful. It will be a RFA that requires for both Medicaid and state-

funded services. So just yesterday the tailored plans will continue to fund as the LME/MCOs do. The tailored plans will have a state-funded services. The RFA will include evaluation questions that the offerors must complete and submit to the state to be considered for a behavioral health I/DD tailored plan contract. The evaluation applications will be based primarily upon the offerors qualifications and the ability to meet expectations for these plans. Obviously we worked with the LME/MCOs in the process so we know them. Ability is paramount in doing this work is that the response to the RFA and that's how we will manage the applications that come in and the award. The offerors will not submit price. None of this is based upon price. The department will set actuarially sound capitation rates which the plans must accept if they are awarded a tailored plan.

The next slide shows the regions. If you have noticed they are exactly the same as the current LME/MCO regions. We engaged the community along with the county commissioners association to work with us to think about regions. The legislation allowed us to change those, but after thoughtful considerations from the county commissioners, and their recommendation of the secretary, that we decided that we would stick with the current regions that the LME/MCOs provide services in, in the seven regions that exist. What we had also decided is that the offerors can only apply for the regions in which they are currently operating as an LME/MCO. Now because we are using a competitive process, there is the possibility that an LME/MCO or multiple LME/MCOs might not meet the minimum criteria to become a tailored plan. So we have to have an empty region process. Those offerors that would like to be considered for an expanded service area in an empty region will be asked to respond to additional questions in a supplemental questions request. The supplemental questions will assess the offeror's experience in and approach to developing provider networks and managing community health functions in regions which they do not currently operate and administrative and operational capacity to manage an expanded service area. The department will also assess the projected enrollment in empty regions and we retain the right to divide a region and award each sub-region to two or more qualified offerors if an award of an empty region would result in a substantial number of new enrollees being added to any one offeror.

So, with that, I'm going to turn it over to Dr. Keith McCoy who is the Senior Medical Advisor for the Division of Mental Health, Developmental Disabilities and Substance Use Services. Dr. McCoy.

**Keith McCoy:** All right. Thanks Deputy Secretary Richard. So, we're going to talk a little bit about how the behavioral health I/DD tailored plan administration and oversight, including governance structure works. So, first, in concert with 122C and session laws that are governing Medicaid transformation, the department has outlined provisions regarding the administration and management of the behavioral health I/DD tailored plans. First, as far as NC's status, behavioral health I/DD tailored plans must be operated, as Dave mentioned, by the LME/MCOs for the first contract period of four years. Therefore, only LME/MCOs can apply to become behavioral health I/DD tailored plans under this initial RFA. LME/MCOs can, however, initiate mergers through the currently accepted process requiring department approval. Furthermore, as far as governance goes, tailored plans will be subject to the same governance requirements that currently apply to today's LME/MCOs. Specifically, it's outlines under general statute 122C and this includes a single governing board and other advisory boards, as follows: First the governing board must be comprised of 11-21 voting members, representing consumers and families, clinical, financial and insurance industry experts. Secondly, they must have consumer and family advisory committee, a CFACs and they must include all local CFAC committees within the plan's region. And they are also can have other advisory boards which are non-binding, advisory-only boards comprised of county commissioners. Plans must comply with all applicable provisions of 122C, Article 4

regarding the composition, meeting schedule, training, compensation and maintenance as each of these governing and advisory boards.

Regarding licensure, LME/MCOs are currently exempt from PHP or prepaid health plan licensing set forth by the North Carolina Department of Insurance. The tailored plans will not be required to have a PHP license as a condition of the initial contract award. But our plan is for them to become licensed as a PHP, at least 90 days before the end of the third contract year. However, that would be contingent upon legislative authority authorizing this conversion.

Next slide. Offerors bidding to become a behavioral health I/DD tailored plan may form strategic partnerships with subcontracting entities. However, the department has both legal and strategic interests in how these subcontracting partnerships work. So first, under the legislation, LME/MCOs operating as tailored plans must subcontract with a prepaid health plan, and this is the quote from the legislation, “that covers the services required to be covered under a Standard Benefit Plan contract.” So a little more about that, the department does not require plans that meet these statutory requirements to hold a standard plan contract or a license in the same region as the tailored plan. The department must review and approve contracts between tailored plans and PHPs. Furthermore, the tailored plans must ensure oversight and monitoring a subcontractor. This is consistent with the guidance we’ve already put out related to standard plans, similar to what’s in the standard plans RFP and contract. The tailored plans must provide the department with copies of executed contracts with any subcontractors. Generally, the department has interest in ensuring that the tailored plans remain integrated products for members, for providers and for the state from our perspective. So the RFA will outline parameters governing the contractual relationship between the tailored plans and their subcontractors. And these parameters focus on financial and operational integration across service types, a unified member experience and a unified provider experience. So a little more specific on that. It is not our intention, for example, for tailored plans to fully subcontract the physical health benefits, such that the management of tailored plan members care is somehow bifurcated.

Now we’ll shift the focus a little bit on quality. So the department seeks to improve outcomes for enrollees by focusing on rigorous and innovative outcome measurements promoting equities through reduction or elimination of health disparities and rewarding behavioral health I/DD tailored plans and providers for advancing the departments quality goals. The tailored plans must meet all standards relevant to standard plans as well as meet additional standards related to unique aspects of the tailored plan population. They must develop quality management and improvement programs, quality assessments and performance improvement plans and at least three performance improvement projects. They must achieve NCQA Health Plan Accreditation with LTSS or long-term services and supports distinction for health plans by the end of contract year three and they must report a wide range of quality metrics, including outcome metrics with variations depending upon whether the enrollee is receiving Medicaid or state-funded services. Please note these standards may change based on modifications to underlying measure sets such as HEDIS. Or changes in state policy priorities. The end of this paper has a pretty comprehensive list of the quality measures that will be in the RFA. What you’ll notice is that some of the additional measures that are specific to the tailored plan population include items related to state-funded services. Items related to individuals that are in the HCBS waiver services, like the Innovations waiver or the TBI waiver. Quality metrics specific to the FTD IMD waiver, that’s part of the 1115. So those will be some of the things that are additional to what you would have seen in the standard plan RFP.

Similar to that, and just reinforcing that, we intend to measure outcomes beyond HEDIS measures, such as measures through AHRQ as those align with the Department priorities. And the Department will reports plans' performance on measures, and beginning in contract year two implement a withhold program for a small subset of priority measures to reflect Medicaid performance.

Now we'll begin reviewing some of the Select Programmatic Features that are unique to the tailored plans. First, In-Reach & Transition. Behavioral Health I/DD Tailored Plans must identify members who are receiving care in an institutional setting and help transition them to the community, if their needs can be met safely in the community. These are principles that have been outlined through North Carolina's TCLI or Transition Community Living Initiative. And the Department intends to continue these priorities for these populations, as well as to begin to expand these priorities to new populations. Specifically, eligible populations for in-reach and transition services include members with serious mental illness residing in an adult care home or a state psychiatric hospital; as well as, and this is one of the new populations, members residing in an ICF-IID or a state developmental center. These are individuals with intellectual disabilities who are in community or state facility institutions.

In-reach activities include ensuring members know about available community-based service options; identifying and addressing barriers to transition; addressing concerns of members or their families who decline or are ambivalent about transitioning; providing opportunities to meet with peers who are living, working, and receiving services in community integrated settings; and supporting facility staff to ensure smooth transitions.

In addition, for those who transition, transition activities will include assisting members prior to discharge; identifying training needed by receiving providers or by receiving agency; addressing barriers to the transition, such as issues with network adequacy or transportation; and addressing potential funding options and needs. For example, some people will have a spend down that needs to be managed. And for adults, these functions will be completed by plan-based staff; and the Department intends to release further guidance about how this will work for children.

Furthermore, for children and youth in behavioral health settings, the tailored plans must also conduct in-reach and transition for youth members who are in state psychiatric hospitals, PRTFs or certain residential treatment levels. In-reach and transition protocols for children and youth include identification and engagement for transition services; collaboration with facilities, community providers, and youth-specific entities or systems; development of individualized, person-centered transition plans; identification and addressing transition barriers; and warm handoffs and linkages to community providers and care managers, where appropriate. Children and youth members residing in state developmental centers and other ICF-IIDs will receive in-reach and transition services as described on the prior slide for adults who are in ICFs, or state developmental centers.

So the other leg of the stool that's essential for the state, the institutionalization priorities, is diversion. The Tailored Plans must identify members at risk of institutional care and help them remain in the community. The Tailored Plans do this by providing diversion services to all members who have transitioned from an institutional or correctional setting within the previous six months and those who are seeking entry into an institutional setting. Other members may also be eligible for diversion services, such as members with an intellectual disability or TBI, who have an aging or ill caregiver and children or youth with I/DD and complex behavioral health needs, who may otherwise have difficult staying in a community integrated setting.

Diversion activities are the responsibility, in the current design, for, of the assigned organization providing Tailored Care Management. And as you may remember from our Tailored Care Management webinars and papers, there are three different types of entities who can do Tailored Care Management. The first is the Behavioral Health I/DD Tailored Plan itself. There are also AMH or Advanced Medical Home plus practices. And then lastly, care management agencies, and those are Behavioral Health or I/DD providers, who are approved to provide the Tailored Care Management model. And the Behavioral Health I/DD Tailored Plan must provides diversion activities to members not already engaged in Tailored Care Management.

And at this point I will hand it over to Deb Goda, who is with the North Carolina DHHS Division of Health Benefits.

**Deb Goda:** Thank you Dr. McCoy. Care Management for folks who are receiving Innovations and TBI Waiver Populations will be administered by the Tailored Care Management agencies, AMH practices or the Behavioral Health I/DD Tailored Plan. We designed the Tailored Care Management model to meet the unique needs of the Innovations and waiver pop -- TBI waiver populations to ensure members have the same access to whole-persons care management as all other members of the Tailored Plan. Specifically for the waiver populations, Tailored Care Management will provide all of the waiver care coordination services that are required as they are today under the Innovations or TBI waivers; coordinating across physical health, behavioral health, long term services and support, pharmacy, I/DD and TBI-related services. It'll provide transitional care management and address members' unmet health-related resource needs.

Behavioral Health I/DD Tailored Plans must auto-enroll these waiver populations in Tailored Care Management at launch and give them the option of obtaining Tailored Care Management through an AMH+ practice, a care management agency, or through the Tailored Plan. The Tailored Plan must institute processes to minimize disruption for members with the transition to Tailored Care Management. This means that waiver members may keep their previous care coordinator as their care manager if the care coordinator meets certain qualifications. These members may also opt out of Tailored Care Management, in which case they will receive care coordination services through the Tailored Plan entity, as care coordination is minimally required by the waiver. In addition, care coordination and care management for the waiver population has to be conflict-free to begin compliance with the HTBS final rules.

Relating to Stakeholder Engagement, we remind you community engagement is a core component of the delivery and administration of Medicaid and State-funded Services. Behavioral Health I/DD Tailored Plans must engage with their county agencies, and community-based organizations to help guide and support the delivery of services to Medicaid members and families in their regions. It must develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with county agencies, Consumer Family Advisory Committees, and Community Based Organizations and build partnerships at the local level to improve the health of their members. They are expected to collaborate with other Department partners, such as the Department of Instruction, Division of Vocational Rehabilitation Services and others, to ensure that members' unique needs are met, and collaborate with North Carolina Housing Financing Agency, the Department and other public agencies to support the expansion of supported housing opportunities available to members with mental illness, I/DD, TBI or Substance Use Disorders.

Provider Networks, in accordance with Statute, must include any willing provider in the physical health networks. The Tailored Plan will maintain closed networks for behavioral health, I/DD, and TBI providers but must include all essential providers as outlined by the Department in their regions unless an alternative arrangement has been approved by the Department.

Plans must meet network adequacy standards for physical health, behavioral health, I/DD, and TBI services, which include standards for time, distance, and appointment wait times as well as accessibility and cultural competency provisions. The Tailored Plans will also be required to provide and protect access to out-of-network providers for their members as required under federal law.

Tailored Plans must submit a network adequacy plan (after contract award and annually thereafter) that describes their approach to meeting network adequacy standards and demonstrates compliance with network adequacy requirements. The Department is committed to promoting access to high-priority evidence-based interventions and providers that can best meet the needs of members; priority areas include access to ECT (electroconvulsive therapy) for indicated conditions and Clozapine utilization for the treatment of chronic psychotic disorders, among other areas. As a part of the network adequacy plan, Tailored Plans will be required to develop and effectuate strategies for developing access and capacity. They will be required to —will be reviewed on these strategies prior to go-live and must report on their progress at least annually.

Tailored Plans will be subjected to requirements for provider payments consistent with Standard Plan practices, including rate floors for in-network physicians, physician extenders, pharmacies (dispensing fees), hospitals and nursing facilities; additional payment based on utilization of specific services; and per member per month payments for Tailored Care Management and medical home fees for Advanced Medical Homes.

For Out-of-Network Providers that are providing physical health services, the plan will be required to reimburse at no more than 90% of the North Carolina Medicaid Direct rate for physical health services provided by an Out of Network provider that refused a contract after the Behavioral Health I/DD Tailored Plan made a good faith effort to contract or was excluded for failure to meet objective quality standards. If the Tailored Plan has not made a good faith effort to contract with the Out of Network provider, then the Out of Network provider will be reimbursed at 100% of the NC Medicaid Direct rate. For Behavioral Health services, the plan will reimburse at 100% of the North Carolina Medicaid Direct rate for behavioral health services provided by Out of Network providers. For Emergency and Post Stabilization care, the plan will reimburse up to 100% of the North Carolina Medicaid Direct rate for emergent or post-stabilization services provided by Out of Network providers. And for Transitions of Care, the plan will provide at 100% of the NC Medicaid Direct rate for services delivered by Out of Network providers during the transition of care as outlined in the RFA.

And now I will turn it over to Medicaid Chief Actuary and Senior Policy Advisor, Julia Lerche.

**Julia Lerche:** Thank you Deb, and good afternoon everyone. Thank you for joining us today. I'll be wrapping up the presentation by discussing the financial management & monitoring requirements that were laid out in the paper. And also go through Next Steps before we turn to questions. So with respect to financial management & monitoring, the Department has developed financial management requirements to monitor and promote program integrity and sustainability. The Department expects the Behavioral Health I/DD Tailored Plan to be a responsible steward of federal, state and local

resources. The approaching to financial management & monitoring is similar to that of standard plans in several ways.

The Capitation Rate Setting for Medicaid. We will be setting, we The Department, will be setting capitation rates for the Behavioral Health I/DD Tailored Plans that include monthly per member per month payments, maternity event payments, which will provide a fixed amount to the Tailored Plans when there is a qualifying first event, and payments for additional directed payments to certain providers that are required in the contract. The Plans will also receive and be responsible for making separate payments to Tailored care management entities. The capitation rate-setting methodology aligns with that for the same process, for the Standard Plans, and will be detailed in the draft Rate Book. The RFA will include a detailed draft rate book that will include historical claims and encounter data, and enrollment data, for the population that is expected to enroll in the behavioral I/DD Tailored plan. It will also lay out the methodology that the Department will use for the capitation rate-setting process for the Behavioral Health I/DD Tailored Plan, and will include draft rates. Those rates will be finalized closer to the launch date, to be updated for more current data before those are finalized.

The Department is also considering including a time-limited risk mitigation program in the contract with the Behavioral Health I/DD Tailored Plan. This is referred to as a risk corridor program, and would help mitigate unexpected significant gains or losses relative to the capitation rates that are provided to the Tailored Plans. The Department is seeking comment from Stakeholders on the use of that type of program in this contract.

There is also a Medical Loss Ratio requirement that is laid out in the statute. The Behavioral Health I/DD Tailored Plan similar to the standard plan, will be required to spend a minimum of 88 cents for every dollar in capitation payments for medical services and other quality improvement activities. If the Plan's medical loss ratio is less than the 88% threshold, then the Plan must either remit a rebate to the Department, or contribute to health-related resources targeted towards high-impact initiatives, or a combination of the two.

With respect to solvency, the plans must have and maintain adequate financial resources to guard against the risk of insolvency. The intention of the requirements around solvency in the RFA are to serve as a glide path to PHP licensure by the Department of Insurance, which is required by the end of contract year 3. The tailored plans will be required to fully fund a risk reserve at 12.5% of total expected annual Medicaid capitation by the beginning of the launch of the Tailored Plans. They will also be required to purchase reinsurance to protect against the financial risk of high-cost individuals or they can propose an alternative mechanism for managing the financial risk. As mentioned before, by the end of Contract Year 3, the Tailored Plans must meet solvency standards for PHPs set forth by the Department of Insurance, and additionally they must maintain ratios of assets to liabilities in line with industry standards and consistent with what's currently required in the LME-MCO contract and also in the Standard Plan contract.

The Department also plans to utilize a premium withhold program. This is a program that would be used to incentivize Tailored Plan performance in a range of possible areas including but not limited to quality improvement; value-based payments; care management; healthy opportunities; and operational effectiveness. In a withhold program, the Department would withhold part of the monthly capitation payment, and that part of the payment would only be made if the Tailored Plan if they met certain performance standards set by the Department.

Other requirements will be in the contract around managing program costs. These are similar to requirements that are also in the Standard Plan contract and are required by statute. First is that risk-adjusted cost growth must be at least two percentage points below national Medicaid spending growth. The Plans also must use the same drug formulary as established by the Department, and ensure the State realizes a net savings for the spending on prescription drugs. The Department will manage these requirements by monitoring annual cost growth of Plan expenditures by Region and population and will review cost growth reports provided by the Behavioral Health I/DD Tailored Plans.

The RFA will also include some provisions around Value-Based Payment. Value-Based Payment models ensure that provider payments are used to incentivize population health, appropriateness of care, improved quality outcomes and other measures of value. The Department will develop a menu of state-approved Value-Based Purchasing model options to assist the Behavioral Health I/DD Tailored Plans and providers in identifying and entering into innovative arrangements that fit this unique landscape and go beyond the Tailored Care Management model. The Department will require Behavioral Health I/DD Tailored Plans to report on these Value-Based Purchasing strategies and progress, which will be compared to Department-defined Value-Based Purchasing targets starting in Contract Year 2. The Tailored Plans and providers will have the flexibility to propose alternative models for approval. And the Department will build Value-Based Payment into the payment model for Tailored Care Management.

All right, on to Next Steps. The Department is accepting comments on the RFA Pre-Release Policy Paper until this Friday, Valentine's Day, February 14th. We are very interested in your feedback, and we look forward to reading your comments. The link to the paper is included on this slide and comments can be submitted to [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov)

Next slide. Your input and feedback is highly valued by the Department, and there are a number of opportunities for your engagement. We have regular webinars, conference calls, meetings, and conferences. You can participate by commenting on white papers that are released, like the one we described today, frequently asked questions, and other publications. And we also post regular updates to our website, you can find on the slide.

DHHS engages with Consumers, Families, Caregivers, and Consumer Representatives, Providers, Health Plans and LME-MCOs, Counties and the General Public. This concludes our presentation, and we will now take questions. Suzanne, I'll pass it to you.

**Suzanne Thompson:** Thank you Julia. Okay, we have a few questions. The first one is probably for you Deb, it says, Will CAP-C and CAP-DA programs use Tailored Plans, and if so, when?

**Deb Goda:** Currently, CAP-C and CAP-DA are not in the Tailored Plan arena. They will remain in fee for service, I believe for the next five years. And individuals will continue to receive their Behavioral Health Services through the Tailored Plan.

**Dave Richard:** There has not been a final determination of when it will be brought in, but they are right now scheduled to be a part of the long-term support and services side, and I think CAP-C has a little bit of a distinction in there. But right now, they are not planning to come into Tailored Plan.

**Suzanne Thompson:** Thank you. Julia, this question is for you. It says, can you discuss again the rebate to the Department concept? Where will the money go, and how will it be used?



**Julia Lerche:** Thank you for that question. So the medical loss ratio requirement requires that Tailored Plans suspend 88 cents of every dollar in capitation on medical services or quality improvement activities. If for example, they only spend 87 percent of their capitation dollars, they must remit back to the Department that one percent that fell below the 88 percent threshold. If, or, they could make contributions to community-based resources that support the quality initiatives of the Department. If the money comes back to the Department, part of that money actually goes back to the Federal Government, that we need to — because Medicaid is a shared Federal State program, one of those dollars will come back. And to the Department, the Department will need to remit it to the federal government. And the remaining dollars I believe go back to the State.

**Suzanne Thompson:** Okay. Dave, this question's for you. Will the supplemental questions for the empty regions be released at the same time as the RFA?

**Dave Richard:** So, it's a great question, and I'll tell you that we are still in the process of making a determination of that, so if people have comments that they would like to submit, please feel free to do so on that. But that is one of those real questions that we're trying to determine at this point.

**Suzanne Thompson:** Okay. We've had a lot of questions about the slides being posted. Normally, it takes two weeks to get the slides and the presentation posted. It will take two weeks for the actual presenta—the recording of the webinar to be posted. However, the slides will be posted within 30 minutes.

**Dave Richard:** So, Suzanne, that's a, that's great in the segue until we've had some other questions that have come different ways about, are we going to extend the time period for people to be able to respond? And I know we've had a lot of folks, especially with the presentation today and others make it something we will consider, and so, we have more information that'll come out pretty rapidly on that.

**Suzanne Thompson:** Okay. The next question says, my company is a licensed outpatient opioid treatment clinic. Will these services be managed by the LME/MCO Tailors Plans and not by any of the Medicaid BHO plans, such as Carolina Complete Care, Optimum Health? Dr. McCoy?

**Keith McCoy:** This is Dr. McCoy. The outpatient opioid treatments, either through an OBOT, so like it's the BOT's own clinic that's in an outpatient clinic, or like a methadone clinic that's more of a facility-based clinic. Those are in both the Standard Plans and the Tailored Plans service array. So, those services are available more broadly than just the Tailored Plans.

**Suzanne Thompson:** Okay. Deb, this one's for you. It says related to innovations and TBI waivers, what is the definition of an essential provider?

**Deb Goda:** That is that the essential providers are outside of the waiver raise, so, those were closed-network providers.

**Keith McCoy:** And so, we monitor network adequacy through our network adequacy standards, which are sometimes time and distance, or other sorts of standards, to make sure that there is adequate capacity and access for members.

**Suzanne Thompson:** And Julia, it says, is the State planning to mirror the accelerated five-year adoption of value-based payments with the same targets in APMs as the Standard Plan, or is the State proposing a different progression of value-based payments?

**Julia Lerche:** We are evaluating the value-based payment opportunities in the Tailored Plans, they may be different than the Standard Plans, but we're evaluating what the opportunities are in that space. We do recognize that there are significant differences both in the populations and the services, and so, as I mentioned, they are being evaluated, the standards.

**Suzanne Thompson:** Okay. Deb, we've had several questions about I/DD providers and IPRS providers, and how they will bill and be reimbursed for their services.

**Deb Goda:** So, the, the Tailored Plan will act as the LME/MCOs act now, as the authorizer and payer of the services, as well as the manager of the network. So, it will be very similar.

**Suzanne Thompson:** Okay.

**Dave Richard:** Yeah, because there will be services that are with mild mental health and substance use needs, mild and moderate, in the Standard Plans, that many providers will want to be in both the networks for LME/MCOs and those, those Standard Plans provide.

**Suzanne Thompson:** And that would be around your ABA providers?

**Dave Richard:** Great place. And in, if the sanction is that they will not have IPRS funding or State funds inside the Standard Plan.

**Suzanne Thompson:** Dr. McCoy, it says rumor has it that the Standard Plans have only agreed to six to eight metrics being reported and checked. The list on this document seems overwhelming.

**Keith McCoy:** So, the list is consistent with the Standard Plan contract, and the Standard Plans have agreed to that contract. What you may be thinking of is, there are a subset of measures that are especially important and those which are subject to withholds in the future. So just with the Standard Plans contract as we mentioned earlier, there will be a subset, a small subset in full of measures that the Department will prioritize through its whole measure by Contract Year 2.

**Suzanne Thompson:** Okay. This one says, will DHHS submit legislation in the upcoming short session to amend the licensure requirements under 122(c)?

**Dave Richard:** I'm looking around the room. I don't believe that that was our intention around a licensure requirement. And so, maybe it would be helpful if the person who's asked the question will send a little bit more detail about what they're looking for. We do know that there are certain things that we have an interest in amending in the short session. We're not sure, considering the, how people have indicated there's going to be a very short session that will be—if we'll have that opportunity or not. But we're still working on a legislative package.

**Suzanne Thompson:** Okay. And the next one, I'm going to let you all chime in to see who needs to answer it. The timelines do not match reality. You have to insurance licensure before you can apply for NCQA health plan. You cannot do them both at the end of three years. Please explain.

**Keith McCoy:** So, some of the LME/MCOs currently have NCQA. It's not the specific health plan. They're behavioral health ones. But the State has a good relationship with NCQA, and we continue to work with them on what the State's needs are with this.

**Suzanne Thompson:** Okay. The next question says, will single-case agreement still exist with both networks. If yes, will providers with SSA's receive 90% or 100% of Medicaid direct rate? Deb?

**Deb Goda:** The, the single case agreements I anticipate will still exist because there needs to be a relationship. I am not certain about the percentage of the rate. If there is a single case agreement, the rate should be outlined in that single case agreement.

**Dave Richard:** Yes.

**Suzanne Thompson:** So, the next one says, how do you define good faith effort in terms of any willing provider?

**Julia Lerche:** Thank you for the question. This is Julia. I can tell you in the Standard Plan contract, we— if I remember correctly, good faith effort is something that needs to be defined by the PHP and approved—submitted to the Department for approval. So, we give them flexibility to define it, but subject to approval by the Department. I can't say whether for sure that will be in the, tailored plan RFA but that is what I believe is in the Standard Plan contract.

**Suzanne Thompson:** Okay, we have two more questions. [coughing] Excuse me. Is the State considering the use of telepsychiatry technology?

**Keith McCoy:** Do you think I should read it?

**Suzanne Thompson:** Yes.

**Keith McCoy:** Suzanne's having a moment. Is the State considering the use of telepsychiatry technology with appropriate security measures to augment network adequacy requirements? She just went away. In this case—

**Deb Goda:** It would be considered—

**Keith McCoy:** Considered, yes—

**Deb Goda:** —would be considered, would be considered consumer provider technology.

**Keith McCoy:** Right. Our little screen jumped around a little bit. But, when the providers have difficulty managing the network to the standards that are the network adequacy requirements, we do allow for plans of correction for that, as well as proposals for how they would meet that with alternative technologies like telepsychiatry. That is something we would consider similar to the Standard Plans, the telepsychiatry/telemedicine policies would be waived, such that the Tailored Plans and Standards had the ability to create their own policy that would have to be submitted to the State for approval.

**Suzanne Thompson:** Thank you. And the next question says, it appears that you are opening TCLI to more individuals than what is currently in the settlement. What is the plan for paying for the additional individuals?

**Keith McCoy:** The TCLI is specific to our TCLI settlement. Our commitment is to continue that beyond the settlement. Once we are finished with the DOJ settlement, our intention is to continue to make sure that the funding is available through the legislature for TCLI initiatives. When we're expanding the

concepts of the institutionalization, that isn't the same thing as TCLI. So, TCLI is a specific process where there are housing slots, where people need the sorts of resources that allow them to live independently in the community, so they are able to manage rent and utilities and negotiate leases, which is slightly different than the broader concept of the institutionalization when it's not necessarily we're trying to get someone in independent housing alone, but rather to get them into community-based services in the context of where they want to live. Be that with a family member and, for example, with children with mental health, we wouldn't be, for example, looking for them to have an apartment on their own. Rather, we want to make sure that families and youth are given the resources that they need to understand what services exist to wrap that child in the community in their own home or as close to their home as possible.

**Dave Richard:** All right. Just to add a little bit to—I think Keith's explanation is absolutely perfect—but one way to think about this is that, TCLI, the DOJ settlement, which we branded as Transitions Community Living, is a very specific settlement that have very specific targets that we have to meet that we believe will be met and will be out of that settlement, I think, in 2021. What's really important for the State has been is that our goal wasn't just to meet the targets in those, those individual targets, but to rather to create a system in which that we continue the, the spirit and the, the direction of what that settlement was about, which is really those community-based services. So, I think that's one way to think about it. Will we hit those targets, we'll manage those, and once the settlement agreement is met and we are out of it, that's one thing, but the State doesn't have any intention of not continuing its effort to support people in that same way.

**Suzanne Thompson:** Okay. We have time for one last question, and Deb, this is for you. It says, will the timeline for launching the behavioral health I/DD Tailored Plan include individuals with Medicare/Medicaid on the Innovations waiver?

**Deb Goda:** So, individuals who are dually eligible who are on the Innovations waiver will continue to receive their Innovations waiver services through the Tailored Plan, but their physical health services, we're currently determining whether or not that would remain within the fee-for-service arena or would be in the Tailored Plan. So, more to follow on that question.

**Suzanne Thompson:** Okay. We have reached our time for today. I'd like to thank all of our presenters and all of our participants. The slides will be presented—be posted on the Medicaid Transformation Web page within the next 30 minutes. The full recording of the webinar will be posted within two weeks. And please use the Medicaid Transformation e-mail address for any comments, concerns or additional questions you have. Thank you.

[End of webinar.]